SOUTH CAROLINA
LIFE AND ACCIDENT AND HEALTH INSURANCE GUARANTY ASSOCIATION

POLICYHOLDER PROOF OF CLAIM

RE: PIEDMONT INSURANCE COMPANY IN LIQUIDATION

CLAIM NUMBER:
INSURED:
ADDRESS:

SOCIAL SECURITY NUMBER: ________________________________

TELEPHONE: __________________________HOME ________________________________WORK

CLAIM IS MADE FOR: ____________ BENEFITS UNDER THE POLICY, AND/OR

____________ RETURN OF PREMIUM

HAS ANOTHER INSURANCE COMPANY PAID YOUR CLAIM?:

_____ NO _____ YES, IF YES, GIVE NAME, ADDRESS AND POLICY NUMBER FOR THAT COMPANY

____

____

ARE YOU READY TO CLOSE THIS CLAIM?: __________________YES __________________NO

TOTAL AMOUNT CLAIMED: $________________________________

ARE YOU ATTACHING TO THIS PROOF ITEMIZED STATESMENT(S) FOR UNPAID CLAIMS? Yes

I HEREBY CERTIFY THAT I WAS A LEGAL RESIDENT OF THE STATE OF SOUTH CAROLINA ON NOVEMBER __, 2001, THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND COMPLETE AND THAT THIS CLAIM HAS NOT BEEN PREVIOUSLY PAID IN FULL OR IN PART BY PIEDMONT INSURANCE COMPANY, ANOTHER INSURANCE COMPANY OR ANY OTHER PARTY. IF APPROVED AND PAID, I HEREBY ASSIGN TO THE SOUTH CAROLINA LIFE AND ACCIDENT AND HEALTH INSURANCE GUARANTY ASSOCIATION ANY RIGHTS I HAVE AGAINST THE LIQUIDATOR UNDER THIS CLAIM.

________________________________ ________________________________

DATE SIGNED INSURED/CLAIMANT

DEADLINE FOR RETURNING THIS FORM IS __________

RETURN TO: POST OFFICE BOX 706
ORANGEBURG, SC 29116

- -

DO NOT COMPLETE, RESERVED FOR ASSOCIATION USE.

AMOUNT APPROVED $______________ CHECK # ______________ DATE PAID ____________________